Utah Department of Health

# Addendum to CHIP Application Form
# Primary Care Network (PCN)

Name: _____ Social Security Number: _____
First Middle Last

## Insurance Information

A. Do you or your spouse have insurance? ❑ No ❑ Yes
**If you answered yes:**

Name of Insurance Company: _____ Phone #: _____

Address of Insurance Company: _____ Group #: _____

Policyholder Name: _____ Policy #: _____ Start Date: _____

If insurance is through an employer, list employer name and phone #: _____

Premium: $_____ Date Due: _____ How Often? _____

Names of Persons Covered: _____

B. Are you or your spouse offered insurance through an employer, of which you have not purchased? ❑ No ❑ Yes
**If you answered yes:**

Employer Name and Phone #: _____

C. Have you or your spouse had insurance that has ended in the past 6 months? ❑ No ❑ Yes
**If you answered yes:**

Why did it end? _____

When did it end? _____

Name of Insurance Company: _____ Phone #: _____

Policyholder Name: _____ Policy #: _____

D. Have you or your spouse been injured in an accident or assault? ❑ No ❑ Yes

**If you answered yes**, explain: _____

E. Are you or your spouse a full-time student? ❑ No ❑ Yes
**If you answered yes:**

Who is the student? _____

What is the name of the school? _____

F. Have you or your spouse ever served in the military? ❑ No ❑ Yes
**If you answered yes:**

Who? _____ Dates of Military Service? _____

G. The adults applying for PCN are: ❑ U.S. Citizens ❑ Legal Aliens ❑ Other
If legal aliens, please provide alien registration numbers: _____

## I Understand that:

❍ I assure that I am a U.S. citizen or alien in lawful immigration status. I also assure that if this application is requesting benefits for my spouse, that he/she is also a U.S. citizen or alien in lawful immigration status. The Utah UDOH of Health (UDOH) will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The UDOH will not report undocumented household members to USCIS.

❍ My spouse (if applicable) and I will obey the medical assistance program rules. If I receive medical assistance which I am not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the people named on the medical card to use the medical card.

❍ If the UDOH pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the UDOH any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them.

❍ I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the UDOH has written. I understand that the benefits I am eligible to receive may be changed without my knowledge or consent. I further agree to be responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.

❍ I authorize any person or organization to release medical records or information about my health or the health of my dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about my eligibility for medical assistance.

❍ The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older.

❍ I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

_____ _____ _____

Signature of the Applicant | Signature of the Spouse or Representative | Date

**VOTER REGISTRATION INFORMATION**

**If you are not registered to vote where you live now, would you like to apply to register to vote here today? ❑ Yes ❑ No**

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, Olene S. Walker, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114.

*Action Taken*

**<u>This Section To Be Completed By The Worker</u>** Worker Name:

❑ PCN Info ❑ Rights & Responsibilites / 476 ❑ SAVE

❑ Estate Recovery (55+) ❑ Medicaid For Those With Disabilities

Application Status ❑ Approved ❑ Denied - Reason_____ Date:

Comments:

UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING
NOTICE OF PRIVACY PRACTICES

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003***

The Utah Department of Health, Division of Health Care Financing (DHCF) is committed to protecting your medical information. DHCF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

**CONFIDENTIALITY PRACTICES AND USES**

DHCF may use your health information for conducting our business. Examples:

**Treatment** - to appropriately determine approvals or denials of your medical treatment. For example, DHCF health care professionals who may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient.

**Payment** - to determine your eligibility in the Medicaid or PCN program and make payment to your health care provider. For example, your health care provider may send claims for payment to DHCF for medical services provided to you, if appropriate.

**Health Care Operations** - to evaluate the performance of a health plan or a health care provider. For example, DHCF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

**Informational Purposes** - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

**YOUR INDIVIDUAL RIGHTS**

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *
- Request corrections or additions to your health information. *
- Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the Medicaid/DHCF or PCN Privacy Officer for the appropriate form for your request.

## SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid and PCN programs and the following:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices
- To protect victims of abuse, neglect, or domestic violence
- For health oversight activities such as investigations, audits, and inspections
- For lawsuits and similar proceedings
- When otherwise required by law
- When requested by law enforcement as required by law or court order
- To coroners, medical examiners, and funeral directors
- For organ and tissue donation
- For research approved by our review process under strict federal guidelines
- To reduce or prevent a serious threat to public health and safety
- For workers' compensation or other similar programs if you are injured at work
- For specialized government functions such as intelligence and national security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

**OUR PRIVACY RESPONSIBILITIES**

DHCF is required by law to:

- Maintain the privacy of your health information
- Provide this notice that describes the ways we may use and share your health information
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DHCF offices and on our website, http://health.utah.gov/hipaa. You may also request a copy of any notice from your Medicaid/DHCF or PCN Privacy Officer listed below:

**CONTACT US**

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid, CHIP, and PCN recipients should contact the DHCF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor, PO Box 143102, Salt Lake City, Utah 84114-3102; cdevashrayee@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint.

You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S. W. Room 509F HHH Bldg., Washington, DC 20201